Supreme Court, U.S.
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No. 01-200

IN THE

Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE COMPANY, and THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF PENNSYLVANIA, EASTERN DISTRICT

BRIEF IN OPPOSITION FOR RESPONDENTS

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COUNTERSTATEMENT OF QUESTION PRESENTED

In enacting ERISA and its preemption clause, did Congress clearly intend to truncate the states' traditional roles in the regulation of the quality of health care services and in the enforcement of health care malpractice tort rights by preempting and effectively eradicating claims for personal injury damages caused by the negligence of HMO-employed health care service professionals in the performance of their duties to provide or to arrange for appropriate medical care for the beneficiaries of ERISA plans?

STATEMENT PURSUANT TO RULES 14.1(b) AND 29.6

The petition accurately lists the parties to the proceedings.

Respondent Pennsylvania Hospital Insurance Corporation, In Rehabilitation, ("PHICO") is a subsidiary of PHICO Group, Inc., which is ovned in its entirety by the Health Alliance of Pennsylvania, and is currently in Rehabilitation.

Respondent The Commonvealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund ("CAT Fund") is a statutorily created executive agency of the Commonwealth of Pennsylvania.

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COUNTERSTATEMENT OF THE CASE

A. Introduction

This case involves a state law medical malpractice personal injury damages claim against an HMO medical services provider for its alleged negligence in delaying appropriate emergency medical treatment for a subscriber to the HMO, Basil Pappas, who was unquestionably entitled to that treatment by any capable medical facility, whether or not the facility had a contractual service relationship with the HMO. The HMO, petitioner U.S. Healthcare, functioned as a provider of pre-paid medical services to the ERISA plan which had been established by the employer of the subscriber's wife. The ERISA plan is not a party to this case. There is no claim in this case against the ERISA plan, and no claim challenging the terms of the plan or seeking payment by the ERISA plan. There is no evidence that the HMO acted as the ERISA plan's administrator. The obligations of the HMO in this case are no different from its obligations toward any of its subscribers, whether or not they are beneficiaries of an ERISA plan.

This is the second time that this case has reached your Honorable Court. On the first occasion, your Court granted certiorari, summarily vacated the judgment of the Pennsylvania Supreme Court in *Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998) ("*Pappas I*"), and remanded for reconsideration in light of *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000). *United States Healthcare Systems of Pennsylvania, Inc. v. Pennsylvania Hospital Insurance Co.*, 530 U.S. 1241 (2000). On remand, the Pennsylvania Supreme Court received new briefs from the parties and from the

Solicitor General on behalf of the Secretary of Labor and then did exactly what your Court directed it to do, *Pappas v. Asbel*, 768 A.2d 1069 (Pa. 2001) ("*Pappas II*").

In its second attempt to obtain review of the merits of this case by your Honorable Court, petitioner roots its analysis and its arguments largely on its selective reading of what the Pennsylvania Supreme Court said in *Pappas I* and on the shift that *Pegram* inspired in the position of the Solicitor General between *Pegram* and *Pappas II*.[1] Petitioner also attempts to draw an irreconcilable conflict between *Pappas II* and the decision of the United States Court of Appeals for the Third Circuit in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.2d 266 (3d Cir. 2001) and decisions from other jurisdictions.

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1. Petitioner points to the Pennsylvania Supreme Court's statement, arguably *dicta*, in *Pappas I*, that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." (App. 29a). Petitioner unaccountably ignores the clarifying next sentence of the court's opinion, which expressed its narrow *holding* that claims that an HMO caused bodily harm by negligently delaying the delivery of the medical services which it promised to provide were claims regarding the provision of safe medical care and that Congress did not intend to preempt the states from adjudicating those claims (App. 39a). Likewise, petitioner stresses selective quotations from the brief filed by the Solicitor General with your Honorable Court, but fails to provide your Court with the brief that the Solicitor General filed with the Supreme Court of Pennsylvania in *Pappas II*, in which the government candidly acknowledged that it no longer adhered to the statements which the petition now disinters. *See* p. 4a of the Solicitor General's brief attached as the appendix to this brief in opposition ("Because the Secretary's views of this case have changed in light of *Pegram*, and because this is the first opportunity to express those views since *Pegram*, the Secretary has a strong interest in participating in this stage of the proceeding.").

What is now at issue, however, is what was said by the Pennsylvania Supreme Court in *Pappas II*. Because what that court said in *Pappas II* comports fully with the controlling decisions of your Court, respondents PHICO and the CAT Fund respectfully ask that your Honorable Court either deny the HMO's petition for writ of certiorari, as your Court did in *Aetna U.S. Healthcare v. Lazorko*, 121 S. Ct. 2552, 2001 U.S. LEXIS 4732 (2001) and in *U.S. Healthcare, Inc. v. Bauman*, 530 U.S. 1242 (2000), or that your Court grant the petition and summarily affirm the judgment of the Pennsylvania Supreme Court in *Pappas II*. If necessary, your Court could note its disapproval of the analysis of *Pryzbowski* and the other cases advocated by petitioner, or could distinguish *Pryzbowski,* as involving a delay in making a benefit determination, and directly related to plan administration, as opposed to a negligent medical judgment concerning which independent provider was capable of supplying the care needed within the time it was needed.

B. Factual Background

The opinion of the Pennsylvania Supreme Court accurately sets forth the factual background. App. pp. 2a-3a, 12a-13a.[2] However, because the issue arose on U.S. Healthcare's motion for summary judgment in the trial court (as opposed to a petition for removal), the facts and their inferences must be viewed in the light most favorable to the respondents.

As the Pennsylvania Supreme Court duly noted and considered, Dr. Dickter, the Haverford emergency room physician who personally attempted to persuade the HMO

2. The Solicitor General's brief noted a similar factual background (Respondents' App., pp. 15-16a).

to change its veto against transporting Mr. Pappas to the non-affiliated hospital that he had ascertained was ready to promptly and properly treat Mr. Pappas, testified that he emphasized to the HMO representatives that the situation confronting Mr. Pappas was a neurological emergency, and that his pleas for the HMO to reevaluate and change its decision were reviewed and disapproved by the HMO's Medical Director, Dr. Liebowitz. *See* Reproduced Record, pp. 70a-72a, 77a (deposition testimony of Dr. Dickter), and pp. 93a (typewritten transcript of emergency room chart).

When viewed in the proper perspective, the record facts of this case suggest that the ultimate decision by the HMO's Medical Director was completely or predominately a medical determination, either that Mr. Pappas' condition was not a true emergency or that there was no need to have him treated at a hospital that was not affiliated with the HMO. There is no question in this case that Mr. Pappas alleged a medical condition which required emergency medical care. There is also no question that Mr. Pappas was entitled to have U.S. Healthcare pay for treatment at any capable facility if his situation was an emergency. Nor is there any claim for the payment of such emergency service.[3]

C. Procedural History

Basile and Theodora Pappas filed a complaint against David Asbel, D.O. and Haverford Community Hospital ("Haverford"), alleging, *inter alia*, that those defendants were negligent in failing to timely diagnose and treat Mr. Pappas'

3. The Solicitor General's brief noted that coverage for emergency care was required by both federal and state law, and that the facts indicated that the HMO's decision was a mixed treatment and eligibility decision, Respondents' App., pp. 15-17a.

spinal cord compression. App. pp. 47a-58a. Haverford joined petitioner U.S. Healthcare as an additional defendant. App. pp. 59a-61a. Haverford alleged that U.S. Healthcare "refused to authorize transfer of husband/plaintiff to a hospital selected by physicians at Haverford Community Hospital." App. p. 60a, para. 7. Furthermore, by incorporation of paragraph 24 of plaintiffs' complaint (App. p. 60a, para. 6), Haverford alleged that HMO-PA negligently:

a. fail[ed] to transfer the patient to a hospital capable and competent of administering to his acute medical condition in a prompt and timely fashion;

b. delay[ed] inordinately in transferring the patient, keeping him at the Haverford Community Hospital during which time his spinal cord compression continued with resultant damage to the patient's spinal cord. App. pp. 54a-55a.

After discovery, U.S. Healthcare filed a motion for summary judgment, claiming that Haverford's complaint must be dismissed under ERISA. The trial court granted the motion for summary judgment, finding that all of Haverford's claims against the HMO fell within the confines of administration of an employee benefit plan, and therefore, were barred under the ERISA preemption provision. App. p. 41a. Ultimately, a settlement agreement was reached among the original parties, and respondents PHICO and the CAT Fund were substituted for Haverford as the real parties in interest against petitioner U.S. Healthcare. App. pp. 45a-46a.

On the respondents' appeal, the Superior Court of Pennsylvania reversed the trial court's decision and remanded

the matter for further proceedings on the merits of the claim. *Pappas v. Asbel,* 675 A.2d 711, 717 (Pa. Super. 1996); App. pp. 18a-33a.

On the HMO's appeal, the Pennsylvania Supreme Court affirmed the reversal and remand ordered by the Pennsylvania Superior Court, but for different reasons, *Pappas I.* The Pennsylvania Supreme Court eschewed the Superior Court's emphasis on the HMO's cost-containment interest (App. p. 39a, n.6).

In determining the approach to be taken in the resolution of the HMO's immunity-through-preemption defense, the Pennsylvania Supreme Court perceived that your Honorable Court's decisions in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) ("*Travelers*"), *California Div. of Labor Standards Enforcement v. Dillingham*, 519 U.S. 316 (1997) ("*Dillingham*"), and *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997) ("*DeBuono*"), marked a narrowing departure from the broader approach to "relate to" that your Court earlier took in determining ERISA preemption in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) ("*Metropolitan Life*"), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) ("*Pilot Life*"). App. pp. 35a-39a.

Following the approach mapped by *Travelers*, *Dillingham*, and *DeBuono*, the Pennsylvania Supreme Court concluded that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." App. p. 39a. More specifically, the court held that claims that an HMO caused bodily harm by negligently delaying the delivery of the medical services which it promised to

provide were claims regarding the provision of safe medical care and that Congress did not intend to preempt the states from adjudicating those claims (App. p. 39a):

> . . . As noted by *Travelers*, Congress did not intend to preempt state laws which govern the provision of safe medical care. *Travelers*, 514 U.S. at 661, 115 S. Ct. at 1680, 131 L. Ed. 2d at 709. Claims that an HMO was negligent when it provided contractually guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care. We believe that it would be highly questionable for us to find that these claims were preempted when the United States Supreme Court has stated that there was no intent on the part of Congress to preempt state laws concerning the regulation of the provision of safe medical care.

Thereafter, your Honorable Court granted the HMO's petition for writ of certiorari, summarily vacated the Pennsylvania Supreme Court's order, and remanded the matter for reconsideration in light of *Pegram*.

On remand, the Pennsylvania Supreme Court accepted new briefs from the parties and from the Solicitor General on behalf of the Secretary of Labor.

In his brief to the Pennsylvania Supreme Court in *Pappas II*, the Solicitor General reached the same conclusion, stating,

> Nevertheless, Dr. Dickter's attempt to explain that he had a neurological emergency, and the

> involvement of a USHC physician in USHC's decision, suggest that USHC's transfer decision may have involved some exercise of medical judgment as to whether an emergency existed or, assuming an emergency existed, whether the non-affiliated hospital that Dr. Dickter recommended was as well-equipped as the HMO-affiliated hospitals to deal with the emergency. In either case, USHC would have made a mixed treatment and eligibility decision.

(Respondents' App., pp. 16-17a) The Solicitor General's brief also noted that Justice Nigro concluded in his concurring opinion in *Pappas I* that the HMO's actions "constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan," (Respondents' App., pp. 17a, n.11) an observation which the majority opinion in *Pappas II* acknowledged to have "anticipated the Supreme Court's reasoning in *Pegram* (App. p. 6a, n.3).

Appropriately considering *Pegram* and the briefs and record before it, the Pennsylvania Supreme Court again concluded that the claims against the HMO were not preempted. The court confirmed its original disposition by affirming the judgment of the Superior Court and remanding the case for further proceedings in the trial court. App. p. 14a.

In reaching that disposition, the court first recounted the remand directive from your Honorable Court, the pertinent history and facts, and its earlier analysis. App. pp. 1a-6a. It then turned to and thoroughly analyzed *Pegram*. App. pp. 7a-11a. It then drew from *Pegram* and from

Travelers the recognition that a personal injury claim which was based on a "mixed eligibility and treatment decision" by an HMO was not preempted. App. 11a. Finally, the Pennsylvania Supreme Court turned to the record and, viewing the facts and drawing inferences in the light most favorable to the parties which opposed the HMO's motion for summary judgment, perceived that the HMO's Medical Director did not simply make a simple decision on coverage, but rather rejected another doctor's clinical judgment and rendered a mixed eligibility and treatment decision which was not preempted by ERISA. App. pp. 12a-13a.

Justice Saylor filed a dissenting opinion. He recognized, however, that *Pegram* did not require a reversal of the court's decision, and that claims based upon mixed eligibility and treatment decisions were not preempted by ERISA. App. pp. 16a, 17a-18a, 28a-29a. Expressing his belief that the court had to address two additional points relating to the duty or the standard of care for HMO's, Justice Saylor sought to have the court leave the preemption question open to allow the HMO to assert preemption after the trial court had devised proper jury instructions regarding the HMO' duty or standard of care. App. pp. 17a-29a. The majority of the Pennsylvania Supreme Court noted that the questions regarding the HMO's liability were not raised by its preemption claim and were yet to be determined in the case. App. p. 14a, n.7; *see also* p. 40a, n.7.

REASONS TO DENY THE PETITION OR TO SUMMARILY AFFIRM THE DECISION OF THE PENNSYLVANIA SUPREME COURT

A. The Approach Taken By The Pennsylvania Supreme Court Regarding The Applicability Of ERISA And Its Preemption Clause Correctly Follows The Approach Most Recently Taken By Your Honorable Court

Petitioner first posits that your Honorable Court should review the decision of the Pennsylvania Supreme Court because that decision failed to follow *Metropolitan Life* and *Pilot Life* and instead followed *Travelers* and *DeBuono*. However, even a casual comparison of those cases confirms that the Pennsylvania Supreme Court correctly perceived a shift in your Court's approach to a determination of what state laws "relate to" an ERISA plan. Your Court's more recent decision in *Pegram* reinforces that conclusion.

The earlier *Metropolitan Life/Pilot Life* approach emphasized the general nature of the ERISA preemption clause's "relates to" phrase and the structure of the ERISA preemption and exception clauses: if the matter had some impact on an ERISA plan, then it may be preempted, unless it fell within the scope of the insurance exception to preemption. Thus, under the original approach delineated in *Metropolitan Life/Pilot Life*, conduct that does or might affect an ERISA plan is presumptively preempted unless it falls within the scope of the exceptions to ERISA's broad preemption provision. *Metropolitan Life, supra*, 471 U.S. at 739; *Pilot Life, supra,* 481 U.S. at 47-48.

In contrast, the later approach delineated in *Travelers* and *DeBuono*, began with the recognition that emphasis on the "relate to" phrase can produce a sweep of federal preemption far beyond the scope intended by Congress when it enacted ERISA, because virtually everything can be connected to an ERISA plan. *Travelers, supra*, 514 U.S. at 655; *DeBuono, supra,* 520 U.S. at 813. The *Travelers/ DeBuono* analysis also recognized that the operative presumption is against preemption, not for preemption, and it placed on the party claiming preemption "the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law'." *DeBuono*, 520 U.S. at 814, quoting *Travelers*, 514 U.S. at 654. When Congress enacted ERISA, all of the states had traditionally allowed, and regulated to varying extents, health care malpractice claims. "And yet there is not so much as a hint in ERISA's legislative history or anywhere else that Congress intended to squelch these state efforts." *Travelers*, 514 U.S. at 665. As the Solicitor General stated in his brief to the Pennsylvania Supreme Court, "In determining whether ERISA preempts a state law, the Court should start with the presumption that Congress did not want to preempt a state's historic police powers in areas such as regulation of medical care, unless there is a clear and manifest intent to the contrary." Respondents' App., p. 4. Notably absent from the HMO's petition is a citation to a specific prohibition against health care malpractice claims asserted against health care providers, either in ERISA or in the Department of Labor's implementing regulations.

Petitioner attempts to make much of the fact that your Honorable Court did not overrule *Metropolitan Life* and *Pilot Life* when it decided the later cases. However, your Court had no reason to overrule those cases when it decided

Travelers and *DeBuono*. *Metropolitan Life* presented state action that squarely affected the substantive provisions of an ERISA plan. *Pilot Life* presented a state action that squarely conflicted with ERISA's contractual enforcement provisions. Because the state actions in those cases clearly "related to" ERISA plans and plainly conflicted with federal provisions, your Court had no reason to denounce those decisions. *See DeBuono*, *supra*, 520 U.S. at 813.

The HMO's arguments miss two additional points. First, your Honorable Court did take a different approach in its later cases after acknowledging that the approach taken in its earlier cases was unworkable. Second, your Court followed the *Travelers/DeBuono* approach when it decided *Pegram*. In that case, your Court stated that *Travelers* "throws some cold water on the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram*, *supra*, 120 S. Ct. at 2158. The Court also saw no congressional intent to usurp, and no benefit in judicially federalizing, state malpractice claims. *Id.* Furthermore, your Court reiterated its holding *Travelers*, *supra*, 514 U.S. at 654-655, that, "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram*, 120 S. Ct. at 2158. That holding echoed and crystallized your Court's earlier observation in *Mackey v. Lanier Collections Agency and Service*, 486 U.S. 825, 833 (1988), that commonplace tort claims were not displaced by ERISA.

The restrictive approach taken by your Honorable Court in *Pegram*; its reaffirmation of a presumption against ERISA preemption of state medical malpractice claims; and its

finding no clear congressional purpose to federalizing those claims are factors that reinforce the accuracy of the Pennsylvania Supreme Court's decisions to approach the preemption determination not from the preemption presumption suggested by *Metropolitan Life/Pilot*, but rather from the more recent perspectives that preemption is not to be presumed but must be explicitly established by its proponent, and that preemption does not obtain simply because there may be some tenuous connection between the HMO defendant and an ERISA plan.

B. The Decision Of The Pennsylvania Supreme Court That The Claim At Issue Was Not Preempted, Because It Was A Mixed Eligibility And Treatment Claim, Is Fully Consistent With Your Honorable Court's Decision In *Pegram*

The core of petitioner's argument to your Honorable Court are the propositions that the claim against it simply "challenges a straightforward and commonplace ERISA plan determination," and that the claim "falls squarely within the preemptive scope of Sections 502(a) and 514(a) of ERISA," because the claim "arises from and directly relates to the administration of benefits under the ERISA-governed health plan, and provides an alternative enforcement mechanism to ERISA," Petition, p. 12. Those propositions, however, cannot be accepted for several reasons.

First, the claim at issue involves only U.S. Healthcare, which is an entity that is completely distinct from the ERISA plan that Mrs. Pappas' employer created. Neither the ERISA plan nor the employer are parties to this case.

Second, there is no evidence that U.S. Healthcare was the administrator of the employer's ERISA plan. To the contrary, U.S. Healthcare's sole apparent role was to serve as a health care service provider to the beneficiaries of the employer's ERISA plan.

Third, the claim in this case does not directly implicate a provision of the employer's ERISA plan. It may fairly be taken as given that the plan's terms included health care benefits for its beneficiaries, and it may be fairly assumed that the plan's terms described the quantity of those benefits in a general manner that allowed the plan to contract with a service provider, such as an HMO or an insurer, to enroll the plan's beneficiaries, who so desired, as members of the HMO or as insureds. However, there is no evidence that the plan's terms delineated the particulars of the insurer's coverage or the scope of the HMO's program. Moreover, there is no evidence that the plan's terms established the quality standards for the services to be delivered by the health care provider, and no evidence that the plan's terms immunized the provider from personal injury or malpractice claims.

Fourth, the case does not simply involve a challenge to a benefits determination. The damages which respondents seek from petitioner are contribution to the personal injury damages suffered by Mr. and Mrs. Pappas. There is no claim for payment for hospitalization or even for ambulance transportation, and there is no claim for injunctive or declaratory relief. Moreover, there is no genuine question that the terms of the HMO's service contract entitled Mr. Pappas to be treated for an emergency at any hospital, not just at the hospitals within U.S. Healthcare's system. To put it bluntly, there was no legitimate question of coverage

for emergencies by an out-of-network hospital.[4] Rather, the focus of the claims against U.S. Healthcare in this case centers on the medical treatment aspects of its conduct, in particular on the implication that its decision rested on its Medical Director's medical determination, such as that Dr. Dickter's clinical diagnosis of an emergency situation was not correct, or that its contract hospitals were as available and as appropriate as the hospital which Dr. Dickter initially selected, or the like.[5]

Fifth, the medical treatment aspects of the HMO's conduct are not subject to ERISA, because they are at least "mixed" decisions under *Pegram*. Petition, pp. 16-17. Petitioner declares that subjecting it "to state tort law liability

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4. To the extent that U.S. Healthcare argues that coverage was its sole concern, that argument simply underscores its negligence in failing to properly consider the medical circumstances of Mr. Pappas' situation.

5. In its brief to the Pennsylvania Supreme Court, the government reached the same conclusion, stating,

> Nevertheless, Dr. Dickter's attempt to explain that he had a neurological emergency, and the involvement of a USHC physician in USHC's decision, suggest that USHC's transfer decision may have involved some exercise of medical judgment as to whether an emergency existed or, assuming an emergency existed, whether the non-affiliated hospital that Dr. Dickter recommended was as well-equipped as the HMO-affiliated hospitals to deal with the emergency. In either case, USHC would have made a mixed treatment and eligibility decision.

(Respondents' App., pp. 16-17a)

for providing coverage at network hospitals rather than an out-of-network hospital would thus be contrary to – not consistent with – *Pegram*." Most pointedly, however, your Court held in *Pegram* that such decisions are not subsumed by ERISA, even if made by an HMO in its capacity as an administrator of an ERISA plan. Petitioner's assertion cannot stand in the face of your Court's explicit statement to the contrary:

> The kinds of decisions mentioned in Herdrich's ERISA count and claimed to be fiduciary in character are just such mixed eligibility and treatment decisions: physicians' conclusions about . . . making referrals to . . . facilities other than [the HMO's]; about proper standards of care, . . . the reasonableness of a certain treatment, and the emergency character of a medical condition.

Pegram, *supra*, at 2154-2155.[6]

Finally, the ultimate result that U.S. Healthcare seeks in this case is a declaration of immunity from negligence. Although the arguments that your Honorable Court rejected in *Pegram* posited some tangential benefits to federalizing mixed decisions and malpractice claims, such as faster docket movement and potential awards of attorneys fees, U.S. Healthcare's arguments that the claims made against it in this case have to be dismissed under *Pilot Life* raise no comparable universal benefits. Instead, what U.S. Healthcare

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6. The Solicitor General's brief to the Pennsylvania Supreme Court pointed to the same language in *Pegram* to support the government's contention that the HMO's decision in this case was a "mixed treatment and eligibility decision." Respondents' App., p. 17a.

seeks would benefit only itself and other HMOs: complete immunity from any malpractice claim that can possibly be linked to some ERISA plan.

Further consideration of that argument elicits an additional distinction between this case and *Pilot Life* that U.S. Healthcare's arguments fail to appreciate. When Congress entered the field of employee benefit plan regulation through the enactment of ERISA, the legislative choice was between state diversity and federal uniformity, not between a contractual cause of action and no cause of action whatsoever. Congress gave ERISA participants and beneficiaries some contractual cause of action and some relief akin to the cause of action and the relief asserted by the claimant in *Pilot Life*. Because the *Pilot Life* plaintiff retained the federal cause of action and remedies provided by ERISA with respect to the insurer's denial of benefits, the task of your Honorable Court in that case was to determine whether that cause of action and its remedies could be enlarged by the state cause of action and remedy. However, in the context of a health care malpractice action against a service provider, such as this case, the pertinent considerations are very different. In essence, U.S. Healthcare urges the courts to rule that Congress obliterated a traditional state field of law *without providing a parallel federal field of law* as it did with respect to the essentially contractual terms of ERISA.[7] Without a stronger indication of congressional intent beyond what U.S. Healthcare divines from the absence of a malpractice cause of action in ERISA, no court should assume that Congress intended to eradicate state health care malpractice actions against service providers such as the HMO in this case.

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7. That the congressional usurpation was limited to essentially contractual matters is evident in the remedial provisions of ERISA's Section 502(a), as set forth in 29 U.S.C. § 1132(a).

C. Whatever Need There May Be For Further Clarification By Your Honorable Court Can Be Delivered By A Grant Of Certiorari And Summary Affirmance Of The Decision Of The Pennsylvania Supreme Court

1. Like The Pennsylvania Supreme Court, Most Lower Courts Have Correctly Understood And Followed Your Honorable Court's Decisions In *Travelers*, *DeBuono*, And *Pegram*

In the past, lower court decisions with respect to the extent of ERISA's preemption have varied markedly and incompatibly. Notably, nearly all inconsistencies occurred prior to the decisions handed down by your Honorable Court in *Travelers, DeBuono* and *Dillingham*. Importantly, however, as one author has recognized, *Travelers* "provides much needed guidance for courts asked to identify the line delimiting state laws that Congress intended to preempt . . ." K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 Yale J. Reg. 255, 290 (1996).

In addition to the decision of the Pennsylvania Supreme Court, *Travelers*' influence is now emerging in decisions of other lower courts, limiting ERISA preemption of state law tort claims. These courts have applied *Travelers* and its progeny to come to a more functional definition of "relate to". *See, for example, Corporate Health Ins. v. Texas Dept. of Ins.* 215 F.3d 526, 535 (5th Cir. 2000) (holding that a state law allowing suit for claims of negligent delivery of medical services and imposing vicarious liability on managed care entities is not preempted); *Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp.2d 1013 (C.D. Ill. 1999)

(noting that a claim for failure to diagnose myocardial infarction would not be preempted under § 514(a)); *Prudential Ins. Co. of America v. Doe*, 46 F. Supp.2d 925 (E.D. Mo. 1999) (determining that claims for emotional distress and invasion of privacy are not preempted); *Phommyvong v. Muniz*, No. 3:98-CV-0070-L, 1999 U.S. Dist. LEXIS 3101, *10 (N.D. Tex. March 11, 1999) (concluding ERISA preemption does not apply to claims based upon quality of care received); *Moreno v. Health Partners Health Plan*, 4 F. Supp.2d 888, 893 (D. Ariz. 1998) (finding "no relation between an action for medical malpractice and the recovery of benefits or the clarification of rights to future benefits under an ERISA plan."); *Ray v. Value Behavioral Health, Inc.*, 967 F. Supp. 417, 423 (D. Nev. 1997) (finding claims for negligence, invasion of privacy and infliction of emotional distress are "exactly the sort of generally applicable personal injury laws that § 514 of ERISA does not preempt."); *Dykema v. King*, 959 F. Supp. 736, 739 (D.S.C. 1997) (agreeing that a claim of direct liability for failure to diagnose pulmonary embolism does not "relate to" an ERISA plan); *Nascimento v. Harvard Community Health Plan*, No. 94-2543, 1997 Mass. Super. LEXIS 166, *27 (Mass. Super. Sept. 26, 1997) (holding that the provisions of ERISA do not preempt a claim for failure to provide bone marrow transplantation therapy); *Nealy v. U.S. Healthcare*, 93 N.Y.2d 219-220 (1999) (noting claims for failure to take reasonable steps to provide for patient's timely treatment by specialist do not "relate to" the administration of an ERISA plan). Each of these decisions is compatible with "the general tenor of recent [Supreme] Court cases that reemphasize the strength and vitality of the presumption against ERISA pre-emption of laws of general application." R. Charrow and L. Greenlees, *ERISA Pre-Emption – A Law in Search of a Doctrine*, Health L. Dig., March 1999 at 14.

In like manner, the United States Court of Appeals for the Third Circuit recognized the *Travelers* approach to determining claims of ERISA preemption and rejected the HMOs' claims in similar factual cases in *Dukes v. U.S. Healthcare,* 57 F.3d 350 (3d Cir.), *cert. den.*, 516 U.S. 1009 (1995), *In Re: U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), *cert. den.*, 530 U.S. 1242 (2000) ("*Bauman*"), and in *Lazorko v. Pennsylvania Hospital*, 237 F.3d 242 (3d Cir. 2000), *cert. den. sub nom*, *Aetna U.S. Healthcare v. Lazorko*, 121 S. Ct. 2552, 2001 U.S. LEXIS 4732 (2001).

2. Any Confusion Caused By The Third Circuit's Most Recent Decision In *Pryzbowski* And In Other Decisions That Apparently Depart From Your Honorable Court's Decisions In *Travelers*, *DeBuono*, And *Pegram* Can Be Resolved By Summary Affirmance Of *Pappas II* And Disapproval Of The Contrary Decisions

As the petition for writ of certiorari suggests (Petition, p. 18), the analysis and decision of the Third Circuit in *Pryzbowski* could be read to conflict with the analysis and decision of the Pennsylvania Supreme Court in *Pappas II.* Yet, since the delay in that case which allegedly caused the harm, was not a delay caused by a negligent medical judgment to refer a patient to providers incapable of providing needed care in a timely fashion, but rather was a delay in the benefit determination process itself, *Pryzbowski* is arguably distinguishable as a benefit determination. Even if read to conflict with *Pappas II*, the precedential value of *Pryzbowski* is highly suspect because it is a panel decision which facially conflicts impermissibly with the prior and binding Third Circuit panel decisions in *Dukes*, *Bauman*, and *Lazorko*, despite the *Pryzbowski* panel's attempts to distinguish those

cases. Furthermore, the precedential value of *Pryzbowski* is questionable because its analysis and decision appears clearly at odds with your Honorable Court's pronouncements in *Pegram*.

Petitioner criticizes the Pennsylvania Supreme Court for not addressing *Pryzbowski* "in the face of Justice Saylor's discussion of *Pryzbowski* in his dissent" (Petition, p. 19). But it was, most likely, the institutional weakness of *Pryzbowski* that prompted Justice Saylor to relegate it to footnotes and to attempt to distinguish it (App. note 3 at pp. 17a-18a; note 6 at p. 20a), and why the majority opinion did not see fit to discuss it. Moreover, while the *Pryzbowski* panel interpreted and applied *Pegram* differently from the majority of the Pennsylvania Supreme Court, Justice Saylor "agree[d] with the majority that nothing in *Pegram* requires a full reversal of its prior decision" (App. 16a).

To the extent that your Honorable Court believes that further clarification of the law with respect to personal injury malpractice claims against HMO health care service providers is necessary, respondents respectfully suggest that the message can be delivered quickly and forcibly by the Court's simply granting the petition for writ of certiorari, summarily affirming *Pappas II* in light of *Pegram*, and noting its disagreement with *Pryzbowski* and similar cases.

CONCLUSION

Because the decision of the Pennsylvania Supreme Court is fully consistent with your Honorable Court's holdings in *Travelers*, *DeBuono*, and *Pegram*, respondents respectfully suggest that your Court deny the HMO's petition for writ of certiorari in this case, as it did in *Aetna U.S. Healthcare v. Lazorko*, 121 S. Ct. 2552, 2001 U.S. LEXIS 4732 (2001), and in *U.S. Healthcare, Inc. v. Bauman*, 530 U.S. 1242 (2000).

In the alternative, respondents respectfully suggest that your Honorable Court provide further guidance to the lower courts and resolve the apparent discrepancies among their reported decisions by granting the petition for writ of certiorari, summarily affirming the decision of the Pennsylvania Supreme Court in light of *Pegram*, and noting its disagreement with the apparently contrary decisions, such as *Pryzbowski*.

Respectfully submitted,

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APPENDIX

APPENDIX — BRIEF FOR THE SECRETARY OF THE UNITED STATES DEPARTMENT OF LABOR AS *AMICUS CURIAE* DATED SEPTEMBER 22, 2000

IN THE
SUPREME COURT OF PENNSYLVANIA

No. 0098 E.D. Appeal Docket 1996

BASILE PAPPAS & THEODORA PAPPAS, H/W,

Plaintiffs,

v.

DAVID S. ASBEL, D.O.,

Defendant,

PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) and THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND),

Defendants/Appellees,

v.

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Additional Defendant/Appellant.

BRIEF FOR THE SECRETARY OF THE UNITED STATES DEPARTMENT OF LABOR AS AMICUS CURIAE

Appendix

On Remand from the Order of the United States
Supreme Court, No. 98-1836, dated June 19, 2000

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Appendix

STATEMENT OF THE QUESTION INVOLVED

Whether, in light of *Pegram* v. *Herdrich*, 120 S. Ct. 2143 (2000), Section 514(a) of the Employee-Retirement Income Security Act (ERISA), 29 U.S.C. 1144(a), preempts a state law action arising from a health maintenance organization's alleged negligence in denying authorization for certain emergency medical treatment under an ERISA-governed plan.

* * *

INTEREST OF THE SECRETARY OF LABOR

At the request of the United States Supreme Court, the Solicitor General, on behalf of the Secretary, filed a brief expressing views on whether to grant United States Healthcare's (USHC's) certiorari petition in this case, which sought review of this Court's decision in *Pappas* v. *Asbel*, 555 Pa. 342, 724 A.2d 889 (1998).[1] The government argued

1. The Secretary of the United States Department of Labor has a strong interest in preemption issues under the Employee Retirement Income Security Act (ERISA) because the Secretary is charged with administering and enforcing Title I of ERISA. See 29 U.S.C. 1002(13) (defining "Secretary"), 1132(a)(2), (5), 1135. The Secretary has participated as amicus curiae in a number of cases raising ERISA preemption issues in federal and state courts in the health care context. See, *e.g.*, *Nealy v. US Healthcare HMO*, 711 N.E.2d 621 (N.Y. 1999); *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), cert. denied, 120 S. Ct. 2687 (2000). The Solicitor General of the United States has also presented the Secretary's views to the United States Supreme Court in such cases. See, *e.g.*, *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645 (1995).

that, under existing law, the 1998 decision was overbroad and incorrect as applied to the facts as we understood them. The government asked the United States Supreme Court either to grant certiorari or to dispose of USHC's certiorari petition in light of the Court's disposition of *Pegram* v. *Herdrich*, 120 S. Ct. 2143 (2000), which was then pending before the Court.

On June 19, 2000, the United States Supreme Court vacated this Court's decision and remanded for reconsideration in light of *Pegram*. See *United States Healthcare Sys. of Pa., Inc.* v. *Pennsylvania Hosp. Ins. Co.*, 120 S. Ct. 2686 (2000). Because the Secretary's views of this case have changed in light of *Pegram*, and because this is the first opportunity to express those views since *Pegram*, the Secretary has a strong interest in participating in this stage of the proceeding.

ARGUMENT

IN LIGHT OF *PEGRAM*, IT IS UNCERTAIN IN THE PRESENT POSTURE OF THE CASE WHETHER USHC IS ENTITLED TO SUMMARY JUDGMENT ON PREEMPTION GROUNDS

A. *Under Pegram, an important element in the preemption inquiry is whether USHC made a "mixed" treatment and eligibility decision*

1. *General preemption principles.*

Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a), provides

(with exceptions not herein relevant) that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any [ERISA-covered] employee benefit plan." The term "State laws" includes state common law. See 29 U.S.C. 1144(c)(1) (term includes "decisions" having the effect of law); *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 47-48 (1987). Thus, as this Court recognized, the negligence claim against United States HealthCare of Pennsylvania (USHC) in this case is preempted if it "relate[s] to" the ERISA plan through which Mr. Pappas received health maintenance organization (HMO) coverage. See *Pappas* v. *Asbel*, 555 Pa. 342, 345 n.1, 347 n.3, 724 A.2d 889, 890 n.1, 891 n.3 (1998), vacated, 120 S. Ct. 2686 (2000).

In determining whether ERISA preempts a state law, the Court should start with the presumption that Congress did not want to preempt a state's historic police powers in areas such as regulation of medical care, unless there is a clear and manifest intent to the contrary. *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 654-655, 661 (1995) A state law that has a "reference to" or "connection with" ERISA plans is preempted (unless too tenuous or remote); the requisite reference or connection is determined, however, not by the "unhelpful text" of Section 514(a)'s "relate[s] to" language but by ERISA's objectives. *Id.* at 656. Those objectives are:

> 'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives

> among States or between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.'

Id. at 656-657 (citations omitted; Court's alterations).

Thus, Section 514(a) preempts a state law that regulates core ERISA functions, such as one that "mandate[s] employee benefit structures or their administration." *Travelers*, 514 U.S. at 658. Additionally, Section 514(a) preempts "alternative enforcement mechanisms," *ibid.*, such as state-common law actions for improper processing of a claim for benefits. *Pilot Life*, 481 U.S. at 52-57 (such claims are preempted because, among other things, they conflict with Congressional intent that the civil enforcement scheme in Section 502(a) of ERISA; 29 U.S.C. 1132(a), be exclusive).[2] Moreover, apart from Section 514(a), under ordinary conflict preemption analysis, ERISA preempts any state law that directly conflicts with ERISA provisions (*i.e.*, that cannot be accomplished without violating ERISA) or frustrates its purposes. *Boggs* v. *Boggs*, 520 U.S. 833, 841 (1997); see also, *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526, 533 (5th Cir.), on reh'g, 220 F.3d 641 (5th Cir. 2000).

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2. The government has questioned whether *Pilot Life*'s reliance on Section 502(a) of ERISA should apply to state laws that are exempted from ERISA preemption under 29 U.S.C. 1144(b)(2) because they regulate insurance. See *UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358, 376 n.7 (1999). Because there is no claim that the state negligence law at issue in this case regulates insurance per se, *Pilot Life*'s construction of Section 502(a) is applicable.

2. *Prior proceedings in this case.*

In its 1998 decision, this Court held broadly that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan," and therefore are not preempted. *Pappas*, 555 Pa. at 351, 724 A.2d at 893. The Court declined to follow the reasoning of federal courts of appeals holding that certain claims against HMOs are preempted. *Id.* at 351 n.5, 724 A.2d at 893 n.5. See also, *e.g.*, *Danca* v. *Private Health Care Sys., Inc.*, 185 F.3d 1, 5-7 (1st Cir. 1999) (finding preemption under a *Travelers* analysis); *Parrino* v. *FHP, Inc.*, 146 F.3d 699, 705 (9th Cir.) (same), cert. denied, 525 U.S. 1001 (1998).

In recommending that USHC's certiorari petition should be granted, the government argued that this Court's 1998 decision was overbroad. Fundamentally, the government argued, the decision failed to distinguish between USHC's role as a medical care provider and its role as the administrator of an ERISA plan. *United States Healthcare* v. *Pennsylvania Hosp. Ins. Co.*, No. 88-1836 (U.S.), Br. for the United States as Amicus Curiae 6-14 (*USHC*, U.S. Amicus Br.).[3] The government argued that when an HMO provides medical services, it is subject to suit under state law for negligence in performing its medical duties, but that ERISA generally preempts state law challenges to an HMO's actions in making benefits determinations in its role as a plan administrator. *Id.* at 10-11. Believing that a plan coverage decision is plan administration even when medical

3. Because the parties have attached copies of the United States' briefs in *USHC* and *Pegram* to their supplemental filings, we do not attach additional copies here.

judgment is "an adjunct" to it, *id.* at 11, the government stated that on "undisputed" but limited facts of record in this case, this Court did not suggest that USHC "exercised any medical judgment at all," *id.* at 12, and that the state negligence action "necessarily" challenged a benefits determination by USHC. *Id.* at 13; see also *id.* at 15 (arguing that the 1998 decision conflicted with *Pilot Life*). The government suggested that the United States Supreme Court should grant USHC's certiorari petition and either set the case for briefing or vacate this Court's 1998 decision and remand for reconsideration in light of *Pegram* v. *Herdrich*, 120 S. Ct. 2143 (2000), which had not yet been decided.[4]

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4. The government argued that, if the United States Supreme Court agreed with the physician-petitioner in *Pegram* that the intended "benefit" from an HMO is simply membership in the HMO, rather than provision of medical benefits, then the conduct of USHC would not involve a claim for "benefits" under an ERISA plan and would therefore likely not be preempted. *USHC*, U.S. Amicus Br. 19. (The United States Supreme Court did not adopt that categorical argument that the actions of an HMO never constitute plan administration.) The government also argued that if the Court held in *Pegram* that some of the claims in that case involved "administration" and are governed by ERISA, that would effectively hold or strongly imply that claims such as the negligence action against USHC were preempted. *Ibid.* Consistent with that argument, the government argued in *Pegram* that, to the extent the physician incentives at issue in that case constituted plan administration, they involved fiduciary conduct subject to ERISA. The Court, however, held that the HMO's "mixed" treatment and eligibility decisions were not subject to ERISA's fiduciary standards. See *Pegram*, 120 S. Ct. at 2151-2158.

3. *The Pegram decision and its effect on this case.*

In *Pegram*, the United States Supreme Court addressed the scope of fiduciary liability under ERISA. In the course of doing so, it established two overlapping principles that are relevant to this Court's disposition of the instant case.

First, *Pegram* agreed with the government that an HMO may act both as plan administrator and as a medical care provider. *Pegram*, 120 S. Ct. at 2147. In particular, the Court ascribed different roles to HMOs depending on whether they are delivering medical care, making coverage determinations as insurers do, or administering an ERISA plan. See *id.* at 2149, 2151. The Court explained that the term "plan" means "a scheme decided upon in advance," and here "comprises a set of rules that define the rights of a beneficiary and provide for their enforcement." *Id.* at 2151. Thus, while documents setting up the HMO are not an ERISA plan, "the agreement between an HMO and an employer who pays the premiums may, as here, provide elements of a plan by setting out the rules under which beneficiaries will be entitled to care." *Ibid.* The Court reasoned that an HMO may be an ERISA fiduciary "if it administers the plan." *Ibid.*

In discussing an HMO's roles as a medical care provider, the Court distinguished HMOs from traditional fee-for-service provider. In particular, the Court reasoned that an HMO, unlike the fee-for-service providers, agrees to provide specified health care, if needed, for a fixed fee and thus assumes the financial risk that the cost of treatment will exceed the fees received. *Pegram*, 120 S. Ct. at 2149. The financial incentives in an HMO system are thus to provide

less care, not more. *Ibid.* No HMO organization, according to the Court, could survive without some incentive connecting physician reward with treatment rationing. *Id.* at 2150.

The second principle that derives from *Pegram* is that ERISA does not preempt state law that applies to the HMO's medical treatment decisions, even when they are what the Court described as "mixed" treatment and eligibility decisions. The Court reasoned that an HMO, acting through its physicians, makes three kinds of decisions: treatment decisions, pure eligibility decisions, and mixed treatment and eligibility decisions. 120 S. Ct. at 2153-2155. The Court described "treatment decisions" as "choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?" *Id.* at 2154. "Pure eligibility" decisions are ones that "turn on the plan's coverage of a particular condition or medical procedure for its treatment." *Ibid.* "Mixed" treatment and eligibility decisions arise when treatment and pure eligibility decisions "are . . . practically inextricable from one another." *Ibid.* In the Court's view, "many and possibly most coverage" questions are likely to require "mixed" treatment and coverage decisions because they are not "simple yes-or-no questions, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged)." *Ibid.* A coverage question that requires medical judgments about "when-and-how" to provide

treatment gives rise to a "mixed" medical-treatment and eligibility decision. *Ibid.*[5]

Pegram holds that "treatment" decisions and "mixed" treatment and eligibility decisions by physician employees of an HMO are governed by state malpractice standards and not by ERISA fiduciary standards. 120 S. Ct. at 2147, 2157-2158. Indeed, the Court found no "value" in recognizing an ERISA action because such an action "would simply apply the law already available in state courts and federal diversity actions today." *Id.* at 2158. *Pegram* thus rejected the government's understanding, expressed in its briefs in *USHC* and in *Pegram* and based on the pre-*Pegram* case law from various federal courts, that an HMO's coverage decision is plan administration that is subject to ERISA's fiduciary standards even when it involves medical judgment about how to treat a patient, and regardless of whether it is made before or after treatment is provided.[6]

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5. In other words, generally speaking, an HMO is wearing its medical provider hat when making treatment decisions, its plan administrator hat when making pure eligibility decisions, and both hats when making "mixed" decisions.

6. The HMO in *Pegram* was owned by its physicians, who made "mixed" eligibility decisions in the course of treating patients. See 120 S. Ct. at 2147. HMOs such as USHC that contract with independent physicians to provide services make the same kind of decisions in the course of reviewing decisions by treating physicians. Because *Pegram*'s holding, that ERISA's fiduciary standards do not govern "mixed" treatment and eligibility decisions by HMO physicians, turns on the nature of the decision, and not on the structure of the HMO making the decision, the logic of *Pegram*

(Cont'd)

We believe that the United States Supreme Court, by vacating and remanding this Court's decision for reconsideration in light of *Pegram*, has requested this Court to consider and apply the two principles discussed above. We conclude that, following this approach, the Court should hold that USHC may have made a "mixed" treatment and eligibility decision and, if it did, ERISA does not preempt a state negligence action challenging the decision.[7] We also conclude that the case should be remanded for further development of the facts necessary to address the preemption question.

B. *The negligence action in this case is not preempted to the extent that it challenges a "mixed" medical-treatment and eligibility decision*

1. *State law governing "mixed" decisions is generally not preempted.*

As discussed above, *Travelers* requires a court to begin with the presumption that ERISA does not preempt state law

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(Cont'd)
applies to this case. See *id.* at 2155 ("Congress did not intend [the HMO in that case] *or any other HMO* to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians") (emphasis added).

7. Different considerations may apply when an HMO, or other managed care entity, uses medical judgment in deciding whether a claim for treatment that has already been provided should be paid. Those are the sorts of decisions that insurance companies routinely make in determining whether payment should be made under a fee-for-service ERISA plan.

actions in the field of health care. Rather, as *Pegram* confirms, a "clear manifestation of congressional purpose" is necessary for preemption in that area of traditional state concern and authority. *Pegram*, 120 S. Ct. at 2158.

There is no such manifestation of preemptive intent with respect to the general category of treatment decisions that are intertwined with eligibility determinations by an HMO, *i.e.*, coverage decisions that involve or implicate medical judgments (and thus involve or implicate the HMO's role as a health care provider). ERISA's overriding purpose is to protect the interests of participants and beneficiaries, see 29 U.S.C. 1001(b), and Section 514(a) was enacted to "round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29,197 (1974 (statement of Rep. Dent). Section 514 (a) will not round out any protection to participants if an HMO can escape responsibility as an ERISA fiduciary for its "mixed eligibility decisions," as *Pegram* holds, and also avoid state malpractice law.[8] Instead, there will be a gap in protection as courts have recognized. See, *e.g.*, *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1333 (5th Cir.), cert. denied, 506 U.S. 1033 (1992).

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8. Section 514 (a), as enacted, was drafted in conference, and there is little legislative history explaining how far it extends. See *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98-100 (1983). The primary sponsors in the Senate understood that ERISA would not preempt local bar associations' regulation of attorneys as attorneys, although it would preempt attempts to regulate the form and content of pre-paid legal services plans. 120 Cong. Rec. at 29,949 (statements of Sen. Javits and Sen. Williams). Legislators therefore appear to have been concerned with protecting the structure, form, and content of plans, not with relieving professionals of their liability for malpractice.

Moreover, allowing state law challenges to medical judgments made in the context of an HMO's mixed treatment and eligibility decisions should not defeat ERISA's goal of ensuring that plans and plan sponsors would be subject to a uniform body of benefits law and not face the administrative and financial burdens of complying with conflicting state laws. See *Travelers*, 514 U.S. at 656. A "mixed" treatment and eligibility decision involves "when-and-how" questions of treatment and coverage that require the application of medical standards to the facts of particular cases. See *Pegram*, 120 S. Ct. at 2154-2155. In general, state tort law "would not threaten uniformity because the determination is an individualized decision that dictates nothing regarding the treatment to be afforded in the next individualized case." Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 Hous. L. Rev. 985, 1058 (1998); see also *id.* at 1064 (criticizing federal appellate decisions holding that ERISA preempts state actions challenging HMO utilization review decisions because "UR involves the individualized application of a standard to particular clinical symptoms"). We see no reason why this general rule against preemption of "mixed" eligibility and treatment decisions should not apply in the circumstances of this case.[9]

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9. Although *Pilot Life*, 481 U.S. at 48-57, holds that ERISA preempts state law actions alleging that an insurer had improperly processed a claim for disability benefits, the disability claim at issue in *Pilot Life* did not involve a claim for medical treatment. See *Black's Law Dictionary* 804 (7th ed. 1999) (defining "[d]isability insurance" as "[c]overage purchased to protect a person from a loss of income during a period of incapacity for work"). Accordingly, the reasoning in *Pegram*, rather than *Pilot Life*, is applicable in this case.

2. *The claim at issue may involve a "mixed" treatment and eligibility decision*

The negligence action in this case concerns USHC's response to a May 1991 medical emergency involving Basile Pappas, a participant in USHC's HMO. Mr. Pappas was in the emergency room at Haverford Community Hospital, complaining of paralysis and numbness in his extremities. *Pappas*, 555 Pa. at 344, 724 A.2d at 890. The emergency room physician, Dr. Dickter, diagnosed a probable epidural abscess pressing on Mr. Pappas's spine, requiring immediate surgery. *Ibid.* Dr. Dickter arranged to transfer Pappas to a hospital with a spinal cord trauma unit that was able to commit to his immediate admission, but the ambulance service that was to transfer Pappas told Dr. Dickter that USHC would not authorize transfer to that hospital. *Id.* at 344-345, 724 A.2d at 890.

Dr. Dickter called USHC to explain that the situation was a neurological emergency. R 67a; see *Pappas* v. *Asbel*, 450 Pa. Super. 162, 166, 675 A.2d 711, 713 (1996), aff'd, 555 Pa. 342, 724 A.2d. 889 (1998), vacated, 120 S. Ct. 2686 (2000). A USHC representative reportedly consulted with a USHC doctor and, fifteen minutes later, another USHC representative called back to confirm that USHC would not authorize the transfer because the transferee hospital was not a USHC participating hospital. R 67a-68a; *Pappas*, 450 Pa. Super. at 166, 675 A.2d at 713. The representative did state that USHC would cover treatment at any of three other participating hospitals, however. R 67a-68a; *Pappas*, 555 Pa. at 344-345, 724 A.2d at 890. In fact, under the terms of the plan, the HMO did not require pre-certification for

emergency care or restrict where such care could be provided. R 156a, 158a.[10]

USHC's alleged negligence thus arises from its involvement in the decision on how to treat a medical emergency. In particular, the negligence claim brought by appellees incorporates the allegations by Mr. Pappas that Haverford damaged his spine by delaying inordinately his transfer, alleges further that USHC refused to authorize the transfer that Haverford selected, and asserts that if Mr. and Mrs. Pappas prevailed against Haverford, USHC would be liable to Haverford for that award. R 12a-13a, 19a.

As the government argued to the United States Supreme Court, there has been no determination that USHC exercised any medical judgment. *USHC*, U.S. Amicus Br. 12. Nevertheless, Dr. Dickter's attempt to explain that he had a neurological emergency, and the involvement of a USHC physician in USHC's decision, suggest that USHC's transfer decision may have involved some exercise of medical judgment as to whether an emergency existed or, assuming

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10. The federal Health Maintenance Organization (HMO) Act similarly requires USHC to reimburse a member for expenses the member incurs for care outside its organization when it is "medically necessary and immediately required because of an unforeseen illness, injury, or condition." 42 U.S.C. 300e(b)(4); see also 42 C.F.R. 417-103(e)(1) (same); *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, 352 (3d Cir.) (USHC is "a federally qualified health maintenance organization"), cert. denied, 516 U.S. 1009 (1995). Since 1996, Pennsylvania has required state-regulated HMOs and other organizations to pay for or provide medically necessary services due to a medical emergency. 40 Pa. Cons. Stat. §§ 3041, 3042 (West 1999).

an emergency existed, whether the non-affiliated hospital that Dr. Dickter recommended was as well-equipped as the HMO-affiliated hospitals to deal with the emergency. In either case, USHC would have made a mixed treatment and eligibility decision.[11] See *Pegram*, 120 S. Ct. at 2155 (such "mixed" questions include, among other things, doctors' conclusions about "making referrals to physicians and facilities other than [the HMO's]" and "the emergency character of a medical condition").

Because the case was decided on USHC's motion for summary judgment — and because it is possible that USHC made a "mixed" medical-treatment and eligibility decision such that a state-law medical malpractice or corporate negligence action challenging USHC's medical judgment would not be preempted for reasons discussed above — we suggest that the Court may wish to vacate the summary judgment in favor of USHC and remand the case for further proceedings on that issue in light of *Pegram*. See *Pappas*, 555 Pa. at 346, 724 A.2d at 891 (on summary judgment, "all doubts as to the existence of a genuine issue of material fact must be resolved against the moving party").

Under *Pegram*, 120 S. Ct. at 2154, a "pure" eligibility decision is one that "turn[s] on the plan's coverage of a particular condition or medical procedure for its treatment," and decides a "yes-or-no" question, "like whether appendicitis is a covered condition (when there is no dispute

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11. Justice Nigro concluded that USHC's actions "constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan." *Pappas*, 555 Pa. at 385, 724 A.2d at 894 (Nigro, J., concurring).

that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged)." A state law action challenging a pure eligibility decision could raise preemption concerns because a pure eligibility decision interprets what the plan means, not just for one claimant but for all claimants with that condition. Allowing state law to govern questions that "turn on the plan's coverage," *ibid.*, could lead to state court decisions mandating coverage, contrary to the intent of the plan sponsor, and to different results in different states, depending on how state law applies to issues of plan interpretation. State laws that "mandate[ ] employee benefit structures or their administration" are preempted under United States Supreme Court precedents (unless saved as insurance regulation). See, *e.g.*, *Travelers*, 514 U.S. at 658.

In this case, USHC could arguably have made a "pure" eligibility decision if it simply misread its plan, contrary to the terms of the plan and its obligations under the federal HMO Act, see *supra*, p. 15 & note 10, to require that emergencies be handled only by hospitals affiliated with the HMO. If so, then it would be necessary to consider whether, notwithstanding ERISA's preemption clause, state regulation of medical care may extend (with respect to emergency treatment or more generally) to regulating an entity that undertakes to provide medical care but fails to do so, even in a context in which the HMO is making a "pure" eligibility decision.

We take no position on that issue here. In our view, there is insufficient information about both the nature of the legal claim that is being asserted in this case and the underlying

facts concerning USHC's conduct to allow a full exploration of that issue by this Court in the current posture of the case. We do not know, for example, whether any state-law duty that might be alleged even in the absence of any exercise of medical judgment by USHC arises from a "corporate negligence" theory or some other source. See *Pappas* v. *Asbel*, No. 0098 E.D. App. Dkt. 1996 (Pa.), Br. of American Med. Ass'n as Amicus Curiae 26-27 (discussing various theories of negligence).[12] Some courts have held that HMOs and their physicians have certain duties as medical care providers that may give rise to nonpreempted state law actions. See *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 163-164 (3d Cir. 1999) (Section 502(a) of ERISA does not preempt charge that HMO was negligent in adopting hospital utilization policies that discouraged certain hospital admissions; plaintiffs "seek recovery for decisions that [the HMO] made in providing and arranging medical services"), cert. denied, 120 S. Ct. 2687 (2000); *Nealy* v. *US Healthcare HMO*, 711 N.E.2d 621 (N.Y. 1999) (claim that primary care physician negligently failed to submit a timely specialist referral form to an HMO for approval fell within the

12. See also *Thompson* v. *Nason Hosp.*, 527 Pa. 330, 339-340, 591 A.2d 703, 707 (1991) (applying "corporate negligence" doctrine to hospitals); *Shannon* v. *McNulty*, 718 A.2d 828, 831, 835-836 (Pa. Super. Ct. 1998) (extending doctrine to HMOs); *Jones* v. *Chicago HMO Ltd.*, 730 N.E.2d 1119, 1128-1129 (Ill. 2000) (same); *Thompson*, 527 Pa. at 340, 591 A.2d at 708 (one who undertakes to render services to another which he should recognize as necessary to protect the other's person may be subject to liability for physical harm resulting from his failure to exercise reasonable care in the undertaking); *McClellan* v. *Health Maintenance Org. of Pa.*, 413 Pa. Super. 128, 139-141, 604 A.2d 1053, 1059 (applying principle to HMO), allocatur denied, 532 Pa. 664, 616 A.2d 985 (1992).

traditional domain of state regulation of health care and was not preempted by ERISA); *USHC* U.S. Amicus Br. 14 n.9 (if Dr. Asbel, the primary care physician in this case, was a network provider, the Pappases could have alleged that USHC was vicariously liable for his malpractice or directly negligent in selecting him as a provider, but no such claims were made). Here, however, the question would be whether breach of any such state-law duty by an HMO is actionable when it occurs in connection with a "pure" eligibility decision in construing coverage under an ERISA plan. *Pegram* does not address that specific question.

For these reasons, we suggest that the Court remand the case for further development on what state law negligence claims are being alleged and for further development of the facts before addressing the preemption question. Cf. *Pegram*, 120 S. Ct. at 2153 (pleadings must "be parsed very carefully" to understand what acts are at issue) In particular, on remand, the Court of Common Pleas may make a factual finding whether USHC made a mixed medical-treatment and eligibility decision, in which event a state-law malpractice or other negligence action challenging the medical decision would not be preempted. If that court finds that USHC did not make a mixed medical-treatment and eligibility decision, the court could then consider whether USHC breached some other state-law duty that might be alleged under whatever facts are found and, if so, consider in the first instance whether any such state law duty is preempted by ERISA.

Appendix

CONCLUSION

The judgment of the Superior Court should be vacated and the case should be remanded for further proceedings as described herein.

Respectfully submitted.

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